CDDO 1.22
Adopted 11-22-13
Cur Rev 11-10-17

Arrowhead West

Community Developmental Disabilities Organization (CDDO)

CRISIS FUNDING REQUEST

Date: ____________________ Requested Start Date:____________________

Name: ____

Address: ____

DOB: ___________________________ SSN: ___________________________

Tier: _________

KAMIS #: ______________ Date of last functional assessment: ______________ On Wait List Since:______________

Medicaid? Yes No Medicaid #:

Insurance? Yes No Insurance Provider/MCO:

TCM & Agency Name: ____

TCM Phone #:_______________________________________TCM E-mail:____

(Please include supporting documentation as needed.)

Service(s) being requested:

- ☐ Day
- ☐ Personal Care Services (Self Directed)
- ☐ Supportive Home Care (Agency Directed)
- ☐ Residential
- ☐ Medical Alert
- ☐ Enhanced Care Services (Respite/Sleep Cycle)
- ☐ Supported Employment
- ☐ Specialized Medical
- ☐ Wellness Monitoring
- ☐ Overnight Respite

Which crisis definition applies to this situation?

- ☐ Requires protection from confirmed abuse, neglect or exploitation or written documentation of pending action for same; or
- ☐ At significant, imminent risk and is capable of performing serious harm to self or others.

Please describe how the current situation meets the crisis definition indicated on page 1. Please include specific examples with dates and time frames. Narrative should describe how gaining access to supports will mitigate the current crisis.

What other services are currently in place? (Mental health, public school, DCF, etc.) Are the current services fully utilized? Please explain:

List and describe the other service systems involved in creating a solution to this situation:

List and describe community resources which have been explored and exhausted prior to making this request. (Examples include Parsons's Outreach Team, MCO Value Added Benefits, Consultation regarding behavior management, Vocational Rehabilitation, etc.) Please explain why these resources are not sufficient to meet the current needs:

Please explain natural resources available that could be utilized in creating a solution. Include why natural supports will not be sufficient or explain why current level of natural supports cannot be maintained.

If requesting residential services and the person is still attending school, what school/district do they attend? Describe if and how the school is engaged to assist with the current situation.

Identified Risk Factors (Check all that apply)

Critical Incidents	Medical Issures	Behavioral Health	Other Risks
☐ Frequent elopement	☐ Epilepsy/Seizure Disorder	☐ Mental health CM	☐ No natural supports
☐ Law enforcement history	☐ Diabetes, health concerns	☐ Challenging behavior (SIB)	☐ Recently in foster care
☐ APS/CPS investigations	☐ Special diets/severe allergy	☐ Alzheimer's/dementia	☐ Recent death in family
☐ Inappropriate sexual acts	☐ Multiple Psychotropic Meds	☐ PICA, excessive drinking	☐ Risk of family dissolution
☐ Recent ICF/ID placement	☐ Multiple medical challenges	☐ Physical aggression	☐ Risk of APS/CPS
☐ Recent ER visit(s)	☐ Seeing 1+ specialists	☐ Needs frequent redirection	☐ Recently moved
☐ Recent hospitalization	☐ Needs 1:1 supervision	☐ Needs 1:1 supervision	
	☐ Recurrent hospitalization	☐ Substance abuse	

Is there any additional information the committee should be aware of? This includes any barriers to placement (familial, financial, behavioral).

By signing below, I consent to the submission of this request and supporting documentation to the Arrowhead West Community Developmental Disability Organization (AWI CDDO) Funding Committee for review and possible recommendation to Kansas Department for Aging and Disability Services (KDADS) for access to HCBS-IDD Program Funds.

______________________________ ____

Date Signature of Individual/Individual's Representative

____

Printed name of Individual/Individual's Representative and if a Representative, the relationship to Individual

Request submitted by:____________________________________Organization:____________________________________

Please include the following documents as applicable:

- ☐ PCSP/IEP
- ☐ Behavior Support Plan
- ☐ Mental health treatment plan or letter from mental health
- ☐ APS reports
- ☐ ANE reports
- ☐ Other____

FUNDING COMMITTEE ACTION

Client Name: ___________________________________

Date: _______________________________

☐ Approved ☐ Denied

Reason:

☐ Approved and submitted to KDADS Date sent:______________________________

Date approved/denied by KDADS:__________________________________

(If denied, inform of appeal rights according to KDADS Policy on crisis and exceptions).

____ ________________________________
Funding Committee Representative Date

____ ________________________________
Funding Committee President Date

____ ________________________________
Funding Committee Vice-President Date

Mail Funding Committee response to person who submitted the request.

Original – Return to TCM/Person submitting the request
Copy - CDDO